READ CAREFULLY - GRACE PERIOD, USE-OR-LOSE RULE, IRS CLAIM SUBSTANTIATION GUIDELINES, TIPS FOR FILING FLEXCOMP CLAIMS

GRACE PERIOD – Applies to Medical Spending Reimbursement Accounts only.

This allows you to submit claims for services received between January 1 and March 15, of the new plan year and request reimbursement from any account balance remaining in your medical spending account from the previous plan year.

You must indicate in Section B of the FlexComp Reimbursement Voucher SFN 16868 if you want medical care expenses received during the "grace period" reimbursed from any balance remaining in your account from the previous plan year. If you select this option, medical care expenses incurred during the "grace period" and approved for reimbursement will be reimbursed first from any amount available in the prior plan year. If the expenses exceed the account balance, you will then be reimbursed from your current plan year medical spending account if applicable.

If you do not indicate on the reimbursement voucher that you want medical care expenses received during the "grace period" reimbursed from any account balance remaining from the previous plan year, your claim will be processed for the plan year in which expenses have been incurred. No adjustments will be made to your account to reprocess the claim.

USE-OR-LOSE RULE – Applies to both Medical Spending and Dependent Care Reimbursement Accounts.

The deadline to file medical and dependent care claims is four (4) months after the plan year ends or April 30. Any unused amounts in a medical spending reimbursement account cannot be used for dependent care expenses or vice versa. Any amounts remaining in these accounts after April 30 are forfeited.

In order for PERS to comply with the IRS requirement for claims substantiation, the following outlines the acceptable forms of documentation to submit in order to ensure your claim for **medical spending reimbursement** will be processed without delay:

• A copy of the page of the Explanation of Benefits (EOB) that lists the breakdown of charges and benefits indicating the deductible, co-insurance, co-payment, etc. from your health, dental, or vision insurance carrier.

•If you do not have insurance coverage, a statement from the provider is required. The statement must include the provider's name, patient name, a fully itemized list of services received, and the date of services. Statements with only a balance forward or balance due cannot be accepted.

•Orthodontic expenses may be reimbursed as payment is required and paid during the plan year. To be reimbursed for orthodontic expenses paid during the plan year; you must submit a receipt from your orthodontist identifying the payment is for orthodontic services and showing the patient name, date and amount of payment.

•For prescription drugs, the documentation (prescription receipt, provider statement, or insurance explanation of benefits) must show the patient name, date, and Rx number or the name of the drug being dispensed.

•Drugs purchased Over-The-Counter (OTC) that are used primarily for medical care will be reimbursed for reasonable quantities without a medical practitioner's note. Detailed cash register receipts will be acceptable documentation for OTC drugs. If your receipt does not clearly show the name of the product, you will need to submit a copy of the front of the box/container for the OTC product. Taxes, shipping and handling fees are also reimbursable.

•Dual purpose Over-The-Counter medicines or products that may have both a medical purpose and a personal, cosmetic or general health purpose; for example, joint supplements, dietary supplements, fiber supplements, massage therapy, weight loss programs, health club dues, will only be reimbursed with a medical practitioner's note stating the diagnosis and recommendation of the OTC medicine or product as part of treatment. NDPERS has developed a form to assist you and your medical practitioner in providing the information we need in order to process claims for these types of services. **Form SFN 58432 FlexComp Letter of Medical Necessity** is available on our website.

Ineligible Expenses - You cannot obtain reimbursement for:

- Costs incurred before coverage is effective or after coverage ends.
- Insurance premiums.
- Discounts given by provider.
- Vitamins.
- Cosmetic procedures; e.g. facelifts, skin peeling, teeth whitening, removal of spider veins, breast reduction.
- Contact lens insurance and maintenance agreements, an eyeglass warranty, clip-on sunglasses.
- Exercise equipment, health club dues, personal trainers used to improve appearance or for general health.
- Massage therapy unless prescribed by a physician to treat a specific medical condition.
- The full cost of a chiropractic maintenance agreement.
- Marriage counseling services.
- Illegal operations or treatments.
- Travel your doctor told you to take for a rest or change
- Services that require pre-payment cannot be reimbursed until after the services have been rendered.

In order for PERS to comply with the IRS requirement for claims substantiation, the following outlines the acceptable forms of documentation to submit in order to ensure your claim for **dependent care reimbursement** will be processed without delay:

For Dependent Care claims your provider must complete Section D or provide a receipt with the following information:

• Name of Provider/If provider is a relative, list relationship
• Tax Identification Number or Social Security Number
• Actual dates on which care was provided (not billing payment date)
• Amount of dependent care expense

Services that require pre-payment cannot be reimbursed until after the services have been rendered.

Day care expenses must:
•Be for the purpose of enabling you or you and your spouse to be employed.
•Be for a child under 13 years of age who is your dependent under Federal tax rules. The child must reside with the employee at least one-half of the taxable year.
•The dependent care account can also be used for the care of a spouse or a dependent over the age of 13 who is incapable of self-care. The adult dependent who is incapable of self care must live with the employee for more than one-half the taxable year and not have more then $3,200 per year in gross income.
•Be provided by someone other than your spouse or another dependent child. If your day care provider is a relative, list relationship.

Eligible Expenses may also include:
•Before or after school care.
•Registration or application fees, if fee must be paid in order to obtain care.
•Day Camp
•Preschool/nursery school
•Transportation expenses, if expenses are for transporting a child to or from place where care is provided and transportation is furnished by day care provider.
•Late “pick-up” fee

Ineligible Expenses - You cannot obtain reimbursement for:
• Costs incurred before coverage is effective.
• Food if billed separately from the dependent care expenses, late payment fees.
• Kindergarten expenses that are primarily educational in nature, regardless of half or full day, private or public school, state mandated or voluntary. However, if your day care provides kindergarten that is run on the order of a nursery school, with the child’s education merely incidental to the care provided and the cost cannot be separated from the cost of the child care, the entire amount can be considered an eligible expense.
•Overnight camp

TIPS FOR FILING FLEXCOMP CLAIMS

Your social security number is no longer required on your FlexComp Reimbursement form.

Your claim form **must** include your Employee ID number. Your Employee ID number is a seven digit number. You must list all seven digits on your form (Example 0123456). Otherwise staff must look the number up and the additional step will delay your claims processing.

The records retention for the FlexComp plan has changed to an electronic filing system. In order to scan documents into this system, we must comply with certain specifications. To avoid processing delays, we would appreciate your assistance by complying with the following:

DO NOT use staples, tape or highlighter on your form or receipts.

Only 8 ½ by 11 inch size paper can be scanned. Therefore, please copy any receipts/statements smaller than this size and send us the copy. Retain the originals for your records.

DO NOT submit two-sided copies.

Use only **blue** or **black** ink for filling out and signing your form.

DO NOT write over or make any notations in the bar code section in the upper right corner of the form.

Copies must be legible and will be returned if unreadable. Your form must be signed or it will be returned to you.